Health Reform in Brazil: Lessons to Consider

US analysts and decision-makers interested in comparative health policy typically turn to European perspectives, but Brazil—notwithstanding its far smaller gross domestic product and lower per capita health expenditures and technological investments—offers an example with surprising relevance to the US health policy context.

Not only is Brazil comparable to the United States in size, racial/ethnic and geographic diversity, federal system of government, and problems of social inequality. Within the health system the incremental nature of reforms, the large role of the private sector, the multitiered patchwork of coverage, and the historically large population excluded from health insurance coverage resonate with health policy challenges and developments in the United States. (*Am J Public Health.* 2003;93:44–48)

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BRAZIL'S STATE HEALTH system dates back to 1923, when the landmark Eloi Chaves Law created a social security system for urban workers employed in the private sector.[1] Because universality and equality of health services did not become constitutional rights in Brazil until 1988, for most of the 20th century access to health services was not an objective of the health system. Instead, a system of "regulated citizenship"[2] developed whereby social rights—including retirement pensions and medical coverage—were restricted to private sector workers who earned regular wages. The Brazilian government had created a model of social security based on compulsory contributions by employers and employees that was strictly tied to the job market, leaving millions of agricultural and informal sector workers—the majority of the population—uninsured. Since the 1920s, the social security administration has provided medical services to its beneficiaries through the private health sector.

Not only did the Eloi Chaves Law govern the structure of the Brazilian health system until the late 1980s, but the most important features of that structure have continued to impede the implementation of principles of universality and equality into the 1990s and beyond. These features include a basic division between health services provided to workers and those provided to the poor population, which remains outside of the formal economy, the separation of individualized medical care from public health policies, and the presence of a private sector that offers increasingly complex, technological, and expensive services to a limited segment of the population. Indeed, a dichotomy has been created within the health care system itself: individual medical care is tied to social security while public health services depend on resources from the general government budget. This model of social security for private sector workers, funded by a specific mandatory contribution deducted from their wages workers—and mediated by the market—prevented "social" security from becoming a truly social or universal right in the Brazilian context.[3–5]

Thus, rather than unifying the population under a single form of medical coverage, the Brazilian health system became polarized into 2 models of health services delivery: liberal (private practice)

medicine operating through the market and institutional (government-run) medicine delivered in public hospitals and clinics.[1] Further, since the mid-1960s, the social security system has purchased health services from for-profit third parties,[6] allowing doctors and medicine to function as businesses as well as guaranteeing professional salaries.[7,8]

The health care financing structure organized in the 1920s and 1930s remained practically untouched until the 1970s. At that point, a process of health reform was initiated, whose first step was extending coverage for particular health services—beginning with urgent and emergency care—independent of the system of social security contributions.[9] In addition to the problem of bifurcated financing, health reform had to address the challenges of centralized decisionmaking; health programs and policies administered, simultaneously, by the social security system, the national Ministry of Health, and state-level Secretariats of Health (which in the 1970s became responsible for the provision of medical care for those not covered through social security); the presence of a strong and diversified private medical sector; a hospital-based health care delivery system operating without regard for regional needs; and little or no public participation in the definition of health priorities at any level of government.

NEW PROPOSALS ON A DEMOCRATIC BASIS

If the challenges of health reform in Brazil can be described as both administrative-technical and political, the impulse for reform was social and political. Dating back to 1975, the movement for Brazilian health reform involved various segments of society, from intellectuals and health services researchers to workers' organizations and political parties.[10,11] Two characteristics of this movement deserve particular attention: it was part of a wider struggle for the democratization of the country during a period of authoritarian regimes, and it had a very well-elaborated proposal for the reorganization of the health system, based on the principles of universality and equality of access to health care.

In the 1980s—at the height of the democratization process—several health experts and members of the health reform movement occupied key positions in the ministries responsible for health services (at that time, the Ministry of Social Security and Assistance and the Ministry of Health).[12] As a result, these ministries began to implement the main reform proposals that had been under discussion, including, among others, the decentralization of the health system and the unified control of the sector at each level of government.

From an ideological standpoint, the health reform positions defended at that point were (and to a large extent still are) marked by a certain misunderstanding regarding the government's responsibility for health and the public provision of services. In other words, the advocates of a Unified Health System understood health to be the exclusive responsibility of the government, conflating the government's role as insurer and as provider of health services. This position proved particularly problematic because private health services accredited by social security were responsible for the majority of hospitalizations and ambulatory services (in 1975, 68.4% of hospital beds in Brazil were private).[13]

When the National Congress elaborated the country's new constitution in 1988,[14] it was the health sector that presented the most complete proposal both in terms of governing principles and in the organization of the system. In the text of the constitution, health was established as a universal right and a responsibility of the state. Article 198 called for a Unified Health System (SUS) that organized a regionalized and decentralized network of health services, with coordinated management at each level of government, community participation, and the prioritizing of prevention as part of an integrated approach to health services delivery. As for the private sector, article 199 of the constitution defined its participation in the SUS as follows: private practice of medicine was permitted, and private institutions could play a complementary role in the SUS (regulated by the SUS), with priority going to philanthropic and not-for-profit organizations.

The guidelines and the new organizational model of the health system were further defined in the Organic Health Law of 1990 (code no. 8080 and 8142). At the stage of implementation, the new system now had to confront the historic legacies of a health system that had heretofore been guided by a logic of either inclusion or exclusion in social security and, in turn, in the private health care market.

Financing

Until 1988, the health sector had been financed principally through social security revenues (contributions from workers and employers through payroll deductions) and, to a much lesser extent, from resources from the national budget for the Ministry of Health. The new constitution established new revenue sources for social security through mandatory contributions tied to the gross revenues and net profits of companies,[15] but for 5 years the old system of social security contributions remained the most important revenue source for the health sector. In 1993, social security stopped providing resources to the health sector, and its financing began to depend exclusively upon the national budget. However, this change in financing occurred in the context of structural adjustment policies promulgated by the International Monetary Fund (IMF) and other international financial agencies and resulted in chronic funding shortages.

Because of the funding crunch, the Ministry of Health became the temporary beneficiary of a new source of revenue created in 1996: a tax on all financial transactions. In 2001, a constitutional amendment reverted the system of financing the health sector to general revenues: the federal government is now required to allocate and spend an amount equivalent to the previous year's budget adjusted for gross national product (GNP) (whose average growth over the past 7 years was 2.4%) and using the 1999 budget (US $9 billion) as a basis. State and municipal governments have also been mandated to increase their spending on health until it reaches 12% and 15% of their respective budgets by 2004.

In the 1980s, the federal share of health spending was 77.7% of the total. By 1996 (the most recent data available), the

federal share experienced a sharp drop to 53.7% of the total, in large measure stemming from the decrease in federal spending owing to fiscal adjustment measures pressed by the IMF.[16] Because of the federal decrease, municipal financing as a share of the total has grown considerably, with an increase of approximately 12% per capita over the same period.[17]

Thus, the 1990s saw a profound change in the financing of the health sector in Brazil—from almost complete dependence on social security revenues to the general funds of federal, state, and municipal budgets. Notwithstanding these changes, overall public spending in health remains at approximately 3.4% of the Brazilian GNP.

Decentralization

The federal constitution delineates the basic structure of the SUS in terms of decentralization of responsibility for the management of health services to subnational levels of government—states and municipalities. Like the United States, Brazil is a federation; it comprises 27 states and 5500 cities, which are vastly different from one another in many respects, such as population size, magnitude and components of the economy, and level and extent of technological development in health and other sectors. In 1991, the Ministry of Health began to set the rules for the transfer of responsibilities to the states and cities,[18] emphasizing the regionalization of health services and federal financial support to those states and municipalities with the equipment necessary to carry out medium- and high-technology services.[19] The objective was to rationalize the provision of health services on the basis of a public–private mix.

In the decentralized SUS, the Ministry of Health operates at the federal level, and its counterparts at the state and municipal levels are organized into Secretariats of Health. Each of these entities has a health fund, which consolidates resources coming from different sources. The National Health Fund transfers resources to the subnational funds according to 2 formulas: direct payment for services provided to the SUS (ambulatory care and hospitalization) and fixed "per capita" transfers for basic health and epidemiological activities, among others. Each entity is accredited by the Ministry of Health, on the basis of its capacity and level of competence, as responsible for either overall management of the health system or management of basic health services only.

The decentralization of the SUS has resulted in considerable progress in health services delivery in several areas. First, although there are enormous disparities among Brazil's cities, state and municipal administrations have enjoyed greater flexibility in adapting services to the local reality. Secondly, the decentralization process has improved the ability of basic health care programs, such as the Family Health Program, to expand access to wider swaths of the population even though universality is still far from being achieved.[20]

In spite of such advances, the implementation of the SUS faces serious obstacles, not only because of the volume of care it needs to provide but also because of its financing system. On one hand, increasing access to care has resulted in ever-higher expenditures. On the other, a renewed public–private segmentation of health services has been created whereby the public sector is responsible for high-volume basic health services as well as high-cost services and the private sector covers more profitable services.[21]

Health Services Provision

In practical terms, Brazil still has 2 health systems: the SUS and the Complementary Medical Care System (SSAM). The SUS operates throughout the country, its 475 699 health professionals attending to the health needs of Brazil's 174.6 million people in 5714 hospitals with 439 577 hospital beds and in 62 865 ambulatory care centers.[22] Although the capacity of the system generates impressive statistics of delivered services, the demand for health services remains dramatically higher than the supply of health facilities and personnel. The SSAM—like its social security predecessor—provides health services to a limited segment of the population. Approximately 33 million Brazilians (19% of the population), whose demographic and economic profiles are similar to those of insured Americans,[23] use 4000 hospitals and 90 000 physicians.[24] As in the United States, most private health plans in Brazil are connected to employment.[25,26]

A significant share of Brazilian health plans are either small or medium in size; they operate via contractual arrangements, providing medical care in private doctors' offices and hospitals. Managed care is only a recent development in Brazil,[27] and health maintenance organizations and preferred provider organizations do not exist. Health plan operators emphasize control, mainly through standardized payment for particular procedures (based on price tables). Still, the result is similar to what occurs in the United States: less choice for users and less autonomy for doctors.[28] Likewise, there is considerable discussion about the impact of managed care on access and universality of care and about the tensions created between patients and doctors.

In sum, health care in Brazil still encompasses dual subsystems, which present distinct forms of institutionalization: the SSAM provides coverage to Brazilians who are younger, present lower risks, and who have higher purchasing power; the SUS provides direct services to those who have a lower or no purchasing power at all, and to those with a higher purchasing power but whose health care needs require a more complex mix of services. Thus, both the provision of and access to health services operate according to a logic of private practice and market principles, to the detriment of a logic that aims to fulfill the needs of the population.[29–32] Notwithstanding the health provisions of the 1988 constitution, the SUS and the SSAM reproduce in a perverse way the mechanisms that create social exclusion and social inequalities.[30]

Social Participation

Social participation in the definition of health policies and in the control of their implementation is one of the founding principles of the SUS.[31] Participation is a prerequisite for resources to be transferred from the federal level to state or local governments. Community participation occurs in health councils, which exist at the 3 levels of government, have a deliberative character, and are

based on parity of membership (members of the government and of society, including users and producers of health services). However, thus far the councils have extended hegemonic power to representatives of government while representatives of society typically raise narrow demands that are of little general interest. Moreover, in reality, the councils simply endorse decisions made by government. Still, the very existence of the councils has increased the number and diversity of social actors engaged in the defense of the right to health.

LESSONS FROM BRAZIL

In Brazil, health care access is no longer organized according to a social security model, be it publicly or privately based. As of 1988, health has been a right granted to all and an obligation of the state. Nevertheless, renewed segmentation of health services into 2 subsystems—the SUS and SSAM—means that the SUS, which is financed exclusively by public resources, is responsible for both the higher-risk population and for more expensive procedures. This segmentation generates a situation of social injustice that is hard to confront. Since 1988, the Brazilian government has been trying to regulate the SSAM in order to protect consumer rights and to spare the SUS from being left with high-cost procedures that health plans prefer not to cover.

Decentralization of health services makes local health systems more attuned to the health needs of the population; moreover, decentralization enables the exercise of public control over health policies. Nevertheless, because decentralized financing has operated on the basis of historical budgets, there is considerable competition for funding among state and local governments. The equitable distribution of resources is thus impeded, and previously existing inequalities in health care access have been reproduced.

Also relevant to the situation in the United States is the recent change made to the model of financing. In the past, supply was subsidized through retrospective reimbursement for each procedure. Nowadays, demand is subsidized in the form of per capita compensation for services. This change seeks to redress the problem of unequal access to care, but it also requires heavy investment in the hospital sector so that the extension of primary care coverage is not stripped down to a basic package of services.[33] Funding transfers between the various levels of government also need to take into account the age distribution, morbidity profile, and per capita income of the population, as well as indices of human and social development.

Advancements in the Brazilian health sector have been made possible as a result of solid health services research, which has brought together researchers, health services professionals, and politically organized groups. Political victory—in terms of the elaboration of the constitution's health provisions—benefited from the health sector's a priori development of a plan for the organization of a national health system.

Finally, the Brazilian case shows that universality and equality of access to health care require that a clear distinction be made between the establishment of health as a universal right and the state's role in the provision of health services. As we have seen, preventing the private sector from participating in the health sector would be impractical in Brazil. Indeed, the effective implementation of the SUS requires that the state and market no longer be understood in radically oppositional terms; instead, the state's role as insurer must be differentiated from its role as a direct purveyor of health services. Moreover, the process of rationalizing the management of resources needs to take into account the fact that public and private spheres gauge cost-effectiveness differently and that the state remains the central player in the redistribution of resources for health in the effort to reach equality. ■

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